

**M D L I N K :**

# Partnering Physicians with Community Organizations

**DEVELOPED IN COLLABORATION WITH  
PHYSICIANS COMMITTED TO IMPROVING  
CARE FOR OLDER ADULTS**

## A Toolkit for Physician Champions

# About The National Council on the Aging

## Who We Are

Founded in 1950, The National Council on the Aging (NCOA) is the nation's first charitable organization dedicated to promoting the health, independence, and continuing contributions of older Americans. NCOA is a 3,200 member national network of organizations and individuals including senior centers, adult day service centers, area agencies on aging, faith congregations, senior housing facilities, employment services, and other consumer organizations.

## What We Do

To accomplish organizational objectives, the following core competencies guide our activities:

- **NCOA is a national voice and powerful advocate** for public policies, societal attitudes, and business practices that promote vital aging. A founding member of the Leadership Council of Aging Organizations, NCOA often leads campaigns to preserve funding for the Older Americans Act. We currently chair and lead the Access to Benefits Coalition to help lower income Medicare beneficiaries find prescription savings. We regularly do public awareness studies such as the Myths and Realities of Aging™ that have helped shape the attitudes of millions.
- **NCOA is an innovator**, developing new knowledge, testing creative ideas, and translating research into effective programs and services that help community service organizations serve seniors in hundreds of communities. NCOA is the leader in identifying and disseminating best practices and evidence-based programming in community-based physical activity, chronic disease management and health promotion activities. In its long history, NCOA has also shaped many innovative aging programs, including Meals on Wheels and Foster Grandparents.
- **NCOA is an activator**, turning creative ideas into programs and services that help community services organizations organize and deliver essential services to seniors. This includes Family Friends and its Center for Healthy Aging. NCOA also administers two federal Programs (Senior Community Service Employment Service and Senior Environmental Program) and the Maturity Works partnership to provide employment and training opportunities for mature adults through offices nationwide.
- **NCOA develops decision support tools** such as BenefitsCheckUp® and the Long-term Care Counselor™, enabling consumers to make optimal decisions and maximize all available resources and opportunities, whether they are looking for prescription savings or understanding their risk of needing long-term care.
- **NCOA creates partnerships** that bring together a wide variety of voluntary, philanthropic, and public organizations to spark innovative solutions and achieve specific results. Each year, for example, NCOA and the American Society on Aging partner to bring a joint annual conference to 4,000 professionals in the field.

**MD LINK: PARTNERING PHYSICIANS  
WITH COMMUNITY-BASED ORGANIZATIONS**

*A Toolkit to Help Physicians Educate Their Colleagues on Collaborating  
with Community-Based Organizations That Serve Older Adults*

*Developed by:*  
**The National Council on the Aging**

*In collaboration with physicians committed to  
improving care for older adults from:*  
**Providence Health System, Portland, OR  
Huntington Hospital, Pasadena, CA  
Harris County Hospital District, Houston, TX  
Lahey Clinic, Boston, MA**

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## SECTION I: OVERVIEW

The expanding population of complex older adult patients increasingly dominates the practice of primary care medicine. The challenging problems that these patients bring to the ambulatory encounter strain the time limits of the visit, tax the clinic's staff, and often leave both the primary care physician (PCP) and older patient frustrated. Because many practices do not have the requisite resources to support patients in the self-management of chronic conditions or optimally manage the concomitant common geriatric conditions or syndromes (e.g., depression, physical deconditioning, poor nutrition), PCPs need to develop partnerships with community resources that can support good chronic care (Wagner, 1998).

Among the most important community resources for older adults and their families are senior centers, area agencies on aging, day service centers, multi-purpose social service organizations, faith-based organizations, and housing programs. Typically these agencies are not-for-profit or public, with a long history of working with older adults in their communities. There are an estimated 27,000 such organizations nationwide. The programs and services they offer older adults include physical activity classes, education programs, support groups, congregate meals, in-home services, and care management. Many of these agencies, referred to in this toolkit as community-based organizations (CBOs), have programs in place that address common geriatric problems including increased risk of falling, managing multiple chronic conditions, combating isolation, and loss of physical mobility. These CBOs are well-positioned to play an important complementary role in optimizing care delivery to older adults (NCOA, 2001), yet many physicians do not know how helpful these organizations can be.

The purpose of this toolkit is to guide a physician "champion" in educating his/her colleagues about the benefits and practicalities of collaborating with community-based organizations that serve older adults. Thus, the toolkit is designed to help a physician champion learn more about community organizations and share what s/he knows with others. It is not a "how-to" guide for building linkages between physicians and local organizations; however, it does include some suggestions for fostering such linkages. In our experience, the "how-to" of such collaborations will vary widely and will be most successful when tailored to the needs and services of the specific physicians and organizations involved.

## The Opportunities and Benefits of Linking PCPs and CBOs

“When older adults have multiple health problems, just keeping up with what they need to do can be overwhelming. They may not know about help they could get with day-to-day living unless their doctor hands them a phone number that links them to a community agency that is ready to help.” *Community Care Manager*

CBOs offer many advantages with respect to meeting the needs of older adults. Many of these organizations already have programs in place that address common geriatric conditions and are well-positioned to play an important complementary role in optimizing care delivery to older adults (NCOA, 2001; HMO Care Management Workgroup, 1999). These programs are often conveniently located in the community thereby facilitating easy access. CBO staff are often members of the same local community and are therefore particularly attuned to cultural needs and preferences. Because many of these organizations develop longitudinal relationships with their participants and clients, staff members are often aware of clinically relevant issues around the living situation and network of social support.

CBOs offer a range of programs and services that complement the goals PCPs are attempting to accomplish with their older patients in the ambulatory clinic. These programs are both general and disease-specific. Illustrative examples include: education on medication adherence, physical activity programs designed for healthy, chronically ill, and frail older adults; positive reinforcement for behavioral change (e.g., diet and smoking cessation); reinforcement and support for clinical preventive services, strategies for coping with loss, stress and social isolation as well as more general health education and health promotion programs. CBOs serving older adults have a long history of delivering in-home or group meal programs and being a resource for information and assistance in accessing many services and agencies that are needed by older adults.

There are many potential advantages of PCP/CBO collaboration. Achieving the goals for care mutually identified by the older patient and PCP can be challenging as they often involve behavioral change or the need to assume a greater role in disease self-management on the part of the older patient. CBO staff can be instrumental in providing ongoing support and positive reinforcement for these interventions. Further, CBO professionals can effectively serve as an additional set of “eyes and ears,” monitoring the patient’s health status and communicating changes back to the PCP and ambulatory clinic personnel.

The literature and the experience of agency staff members document that patients are more likely to connect to these valuable programs and services if the physician makes a referral.

“For many of my clients, the doctor is highly revered, so when their doctor talks to them about getting out to be more active and following up on taking their depression medicine or other goals - it happens. My client knows I am not just making this stuff up.” *Agency Staff Member*

As with all collaborations, the benefits come after some investment in fostering a relationship that works for the physician, the community organization, and the patient. This takes time and maybe some trial and error. And not all communities have the same types of organizations and programs for older adults. The suggestions and materials in this toolkit will not apply to every community and every practice – some adaptations may be required based upon the population and programs in your community.

### **Challenges to be Addressed**

Despite the common ground between PCPs and CBOs – shared commitment to the well-being of older adults and recognition of the importance of health promotion, chronic disease self-management, and supportive services – there is very little collaboration across the two groups. Challenges exist on both sides. These challenges need not stop the collaborative process; rather they are issues that should get discussed so both groups know what to expect

CBOs are heterogeneous and it can be difficult for PCPs to figure out which agencies do what. What appear to be comparable services may not always be uniform in content or quality from one CBO to another. Additionally, differing eligibility and payment criteria can make it difficult for PCPs. In some cases, CBOs have a limited capacity for their programs and services and therefore, patients are added to waiting lists, rather than getting needed services immediately.

There are also potential barriers attributable to the PCP’s role. First, lack of time is frequently the most significant barrier to initiating a new activity in the ambulatory setting. Physicians are facing increasing demands to offer more types of quality care, while the illness burden of patients only seems to grow (Stutz, Robinson and Barry, 2001). And these patient care demands are growing while payment is diminishing. Second, patients may be reluctant to attend a program at a CBO, or take advantage of a service provided by a CBO, particularly if they have not had any previous interaction with the agency. Third, the PCP may need to participate in coordinating care after the referral to the CBO program. CBO professionals rely on the timely responsiveness of the PCP or his/her designated office staff to clarify aspects of the treatment plan, and to be receptive to notifying the CBO of a change in the patient’s health status.

## What Physicians Say

Although these challenges are real, physicians who have made linkages to CBOs report positive results for their patients and their clinic practices. Here are some comments from physicians involved in this project:

- “I don’t need to know all the eligibility criteria for various services. The CBO handles that.”
- “Having a simple paper referral tool means that I don’t need to make a phone call. And the patient and family are more likely to contact the community program if I have made the referral.”
- “Once I established a relationship with a local agency, they helped me with emergency and unexpected situations that arise in the care of elderly patients. This was a great help and time saver.”
- “As a physician, I see so many patients with depression and have no idea who can help them be more active. Knowing how I can call in more help from the community is really valuable. It motivates me to pay more attention to patients who are emotional.”
- “I have received new patients through my relationship with a local agency. People in the community have seen that I deliver good care.”

## How the Toolkit Was Developed

This toolkit is the result of a project conducted by the National Council on the Aging (NCOA) working with physicians and managers affiliated with four community health care systems: Providence Health System, Portland, OR; Huntington Hospital, Pasadena, CA; Harris County Hospital District, Houston, TX; Lahey Clinic, Boston, MA. During the course of the project, NCOA staff and our community partners reviewed the literature on physician-CBO collaboration and on techniques for educating practicing physicians about new resources or services. This information, as well as feedback from our physician champions (the name given to our lead physician partners), helped us shape both the content and layout of this toolkit.

The physician champions on our project team talked with over fifty PCPs, other clinicians, and clinic staff about the following questions:

- What are the barriers that local PCPs identify to making referrals to community organizations that serve older adults? What are some practical ways to address these barriers?
- How interested are local PCPs in collaborating with community organizations? What contributes to a positive interest and what issues dampen that interest?



- What forms of physician education intervention are best suited to delivering information about the value of community services and increasing referrals to and collaboration with these services?

Our physician champions were impressed with how interested their colleagues were in learning more about CBOs and the help they could provide to patients. These findings, reported back by one of our champions, are typical of the comments received.

“Most of the PCPs I talked to were only vaguely aware of CBOs available to assist them in their care of elderly patients. Almost all of the PCPs identified the need for more knowledge about existing CBOs and contact information for CBO services. They were interested in having CBOs come to the various clinics and give brief presentations on the services they could provide, eligibility criteria for patients to receive the services, and what languages were spoken by the CBO staff. The PCPs also identified the need to educate other clinic staff about CBOs and the need to have CBOs do home visits to augment clinic care plans.”

The information and tools included in this toolkit draw upon the experiences of our physician champions and reflect their best thinking on what would help them and other physicians to educate their colleagues about CBOs and to increase linkages with such organizations.

### **Who Should Use the Toolkit**

The toolkit should be used by physicians and their healthcare associates to educate their colleagues about the benefits and practicalities of collaborating with community organizations that serve older adults. The toolkit is designed to be used by physicians who have some experience drawing upon community resources to assist their older adult patients. However, he or she does not need to have a great deal of knowledge about connecting PCPs and CBOs – much of this information can be learned while using this toolkit or made available by knowledgeable healthcare associates. The physicians who use this toolkit should be willing to “champion” referrals to non-medical resources and services as a part of routine practice. They should also have a good working relationship with their physician colleagues and be able to facilitate open discussions about working with CBOs.

During the development of this toolkit, our physician champions were assisted by managers and/or other non-physician leaders in their clinics or hospital systems. Based upon this experience, we believe that using the toolkit and educating physician colleagues is easier and more successful if physicians and non-physician healthcare staff work together. The healthcare staff who took part in this project worked in various capacities, but each one had some knowledge of local community resources

for older adults. They helped the physician champions organize educational sessions with colleagues and identify appropriate CBO representatives within the community.

Throughout this toolkit, we refer to the physician who will be leading the educational effort as the “physician champion.” Additionally, the term “healthcare associate” refers to a manager or other non-physician who is working with the physician champion on this program, and the term “CBO representative” refers to a community agency leader who is helping the physician champion and healthcare associate to implement this toolkit.

## **How the Toolkit Is Organized**

The information in this toolkit is organized into sections to help ease the implementation process for physician champions and their partners. Each section includes a list of the tools that can be found in that section, as well as the purpose of the tools and who should use them. With one exception (the tools in Section II), all the tools are for use by physician champions and their healthcare associates as they educate physician colleagues and clinic staff about working with CBOs. Section II, *Tips for a Community-Based Organization Representative on Working with Physicians*, provides helpful information for the CBO representatives who are enlisted to assist with the implementation of the toolkit.

As described in Section III, the suggestions in this toolkit can be implemented in several stages, or all at the same time, depending on the amount of time available during meetings with physician colleagues and their staff. Please see the suggested “modules” (under *Suggestions for Leading a Discussion with Physicians about Community-Based Organizations*), which can be conducted on different occasions, or as time permits.

Sections IV and V provide more tools that will enhance the educational effort by the physician champion and healthcare associate. Section IV includes tools for gathering information from physicians about their current experiences with elderly patients and community services, about their satisfaction with the educational program and about their next steps. Section V discusses the use of cases to illustrate how CBOs can assist patients and describes three sample cases.

Sections VI through VIII offer definitions of common senior services terms, contact information for national senior service organizations, and other resources that may be helpful for physician champions and their partners. Physician champions may consider providing copies of these sections to their colleagues during meetings.

## SECTION II: TIPS FOR COLLABORATING WITH COMMUNITY-BASED ORGANIZATIONS

### List of Tools

- Tips for the Physician Champion on Engaging a Community-Based Organization Representative
- Tips for a Community-Based Organization Representative on Working with Physicians
- Template for a Physician to Community-Based Organization Referral Form

### **What is the purpose of the two “tips” tools? What problems or issues are they designed to address?**

The *Tips* tools are designed to facilitate communication between the physician champion and representatives of community-based organizations (CBOs) as they prepare to educate physicians and clinic staff. The types of CBOs that would be appropriate for a physician champion to partner with are large senior centers, senior serving social service organizations, area agencies on aging, case/care management agencies, or hospital senior services programs. *Tips for the Physician Champion on Engaging a Community-Based Organization Representative* offers practical suggestions for identifying a CBO representative who is likely to effectively communicate with an audience of physicians and clinic staff, and who can offer concise, practical advice. The physician champion implementing this toolkit should give the second “tips sheet” (*Tips for a Community-Based Organization Representative on Working with Physicians*) to the CBO representative. This sheet provides simple techniques on how the CBO representative can provide useful, essential information in an effective way during a meeting with physicians.

### **When should the “tips” tools be used?**

These tools can be referred to throughout the process of forming a strong connection with one or more CBOs. The tips are useful for getting started and addressing difficulties as they arise.

### **What is the purpose of the physician to CBO referral form? What problem or issue is it designed to address?**

This referral form can help physicians quickly identify those health promotion and/or self-management activities that might be helpful for a patient, as well as specific services (e.g., home-delivered meals) that can support independence. A copy of the form should be given to the patient, which will increase the likelihood of him/her remembering the services you suggest, and will encourage follow-through with the appropriate CBOs. The *Template for a Physician to Community-Based Organization*

*Referral Form* can be modified to reflect the programs and services available through the CBO(s) a physician has selected to work with. CBOs and physicians can use this template, or create their own, based upon the needs of the physician, the patients, and the CBO.

### **When should the referral form be used?**

Ideally, the referral form would be easily accessible whenever an older adult patient visits the physician's office. For example, a blank form could be included in the chart on the day the patient visits. Or the forms could be in the exam rooms, at the nursing station, or at the front desk. The physician or a designated staff member should discuss with the patient which programs or services are recommended, and why. In some cases, it may be appropriate to discuss this with a caregiver who is accompanying the patient. Let the patient influence the choices. Getting the patient or caregiver connected to any service is a good start. If that works well, he/she will be more willing to try other programs that might be more salient to specific medical or health needs.

The patient is much more likely to participate in these programs or services if the physician's office asks the patient to sign the form and then faxes it directly to the CBO. The CBO will then be able to contact the patient and offer help that is specific to the referral form. This technique will help ensure that patients get connected to the services and programs they need in a more timely and efficient manner.

Alternatively, the physician's office can give the patient the referral form and recommend that he/she contact the CBO representative. Encourage the patient to do this and to tell the CBO representative that the physician made the referral. The patient will have a copy of the referral form and will know which services to inquire about.

Depending on the scope of counseling provided by the physician, some clinics have found that physicians can bill for the increased effort required to counsel on prevention services and other patient needs, and/or to coordinate care. The rules that apply to such billing are complicated and we encourage physicians to review relevant codes and to obtain expert advice.

### **Tips for the Physician Champion on Engaging a Community-Based Organization Representative**

1. Start by contacting a leader from a community-based organization (CBO) that you know, or who is recommended by other knowledgeable people. Talk to the potential CBO representative and make sure that the agency offers the types of programs and services that interest your physician colleagues and their patients.
2. It may be more important to find a CBO representative that can engage an audience and be responsive to follow-up questions, than one that knows about all the community's services. It will be important to establish a bond between this community representative and the physicians.
3. The representative needs to be clear, concise, and enthusiastic about what his/her organization can do to help physicians better treat patients. The representative should be a good listener.
4. The representative should be knowledgeable about the following details:
  - specific services of the organization
  - eligibility criteria and fees for those services
  - current waiting times for services
  - languages spoken by CBO staff
  - how physicians can make referrals to the organization
  - what to expect in terms of feedback regarding patients.
5. The representative should provide contact information for a specific person within the organization whom physicians and clinic staff can rely on to address questions and facilitate the referral and feedback process. Remind the representative that physicians and their staff prefer one contact number for all types of services.
6. The representative could be asked to bring carefully selected, program-related or service-related brochures and educational handouts suitable for patients. The physician champion and the CBO can decide together if there are relevant materials.
7. The representative should be prepared to answer questions and offer his/her own view of the sample cases that were discussed at the meeting. The CBO representative will be better able to participate in case discussions if s/he is given information about the case in advance.
8. The physician champion should encourage the CBO representative to solicit questions, concerns, and brief comments from the audience.

### **Tips for a Community-Based Organization Representative on Working with Physicians\***

1. When participating in a meeting of physicians and other clinicians, remember that time is often extremely limited, so be prepared to present your information concisely. Ask how long your presentation should be so you can prepare your discussion points and materials accordingly. Be on time !
2. Physicians want to learn solutions to problems they already have. Ask the physicians about the most prominent issues their older patients are facing and what services they would like more specific information about.
3. Listen to the discussion about sample cases presented at the meeting, and review what services your organization could provide for those patients.
4. Try to answer the physicians' questions as directly as possible, without adding unnecessary information.
5. Be sure to provide the physicians with your contact information, including phone and e-mail address, and discuss with them the best way to communicate (during office hours and after office hours).
6. Provide the physicians with written materials to review and share with office staff about your organization's services, and include enough to be distributed to patients as well. Remember, referrals are easier for physicians and their staff to make if there is a single phone number for all types of services.
7. Be available to return in approximately 2 months, after physicians have had time to work with you. Bring a sample case to discuss – what worked and what did not.
8. Sustain the effort.

\* Many of these ideas were developed as part of an n4a project - Making the Link: Connecting Caregivers with Services through Physicians. For additional helpful information, see <http://www.n4a.org/makingthelink.cfm>.

**TEMPLATE**  
**[Insert Agency/Contact heading]**  
**[Insert Physician Name/Contact heading]**  
**Physician to CBO Referral Form**

**Patient Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Contact Person:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Please Indicate Which Programs Or Services Need Follow-Up:**

**Health Promotion, Self-management**

- ☐ Physical activity
- ☐ Diet and nutrition
- ☐ Support for managing chronic conditions (please specify) \_\_\_\_\_
- ☐ Falls prevention
- ☐ Memory concerns
- ☐ Medication management
- ☐ Social connections
- ☐ Mood concerns – low mood or increased sadness
- ☐ Volunteering and engagement
- ☐ Other (specify) \_\_\_\_\_

**Services**

- ☐ Care management (e.g., social work assessment, coordination of services)
- ☐ Grocery shopping
- ☐ Home-delivered meals
- ☐ Transportation
- ☐ Home safety evaluation
- ☐ Housing – repairs, modifications or alternatives
- ☐ In-home help with cleaning and meal preparation
- ☐ Personal care (e.g., bathing, dressing)
- ☐ Adult day care
- ☐ Legal services
- ☐ Financial assistance/benefits counseling
- ☐ Support/education for caregivers
- ☐ Other (please specify) \_\_\_\_\_

\_\_\_\_\_  
**Physician Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Duration of Conversation**

**Patient consents to Physician sharing contact information with the agency named above.**

**Patient Signature** \_\_\_\_\_

## **SECTION III: EFFECTIVE GROUP DISCUSSIONS WITH PHYSICIANS**

### **List of Tools**

- Suggestions for Leading a Discussion with Physicians about Community-Based Organizations

### **What is the purpose of this tool? What problem or issue is it designed to address?**

The purpose of the *Suggestions for Leading a Discussion* tool is to outline a strategy that will help physician champions plan and facilitate one or more group discussions aimed at educating practicing physicians and clinic staff about CBOs and the resources and services available through these organizations.

The *Suggestions for Leading a Discussion* tool is designed to provide simple, yet practical, tips that can be adapted to a variety of meeting or discussion formats. The physician champion can make changes to the tool in order to suit the situation. The *Suggestions for Leading a Discussion* tool can also be used as a template for a meeting agenda. Creating an agenda can help the physician champion guide the meeting and alerts the participants on what to expect.

The *Suggestions* tool has two basic parts. Part 1 has suggestions about the meeting process – setting expectations, introductions, reviewing the agenda, summarizing and evaluating the meeting. Part 2 briefly describes different content that might be covered in a meeting. We have chosen to refer to these content areas as modules. Four modules are included:

- survey information
- presentation and discussion of sample case(s)
- presentation and discussion by community organization representative
- next steps – for the physicians, clinic staff, the physician champion, and the CBO representative.

### **When and how should the *Suggestions for Leading a Discussion* tool be used?**

These suggestions can be reviewed during the planning stages of a meeting and may be referred to during the group discussion. In thinking about the meeting(s), here are some points to consider:

- This toolkit is designed to support an educational program for physicians; however many times it may be appropriate to involve non-physician providers and clinic staff. The latter should not substitute for the physician; rather the physician and his/her staff would participate as a team.



- A good size for the meeting is about 6-12 participants. This size allows for full participation and diverse points of view. However, the size of the group is not absolutely critical. Good discussion can occur with larger and smaller groups.
- An agenda can be sent out in advance or distributed at the meeting. This helps to provide some focus.

The modules can be discussed during one meeting or over several meetings. It makes sense to start with the survey (Section IV) or sample cases (as provided in Section V or by the physician champion or meeting participants). This will help the physician champion understand how the physicians and their staff think about the challenges of caring for older adults, as well as the use of community services. Similarly, it makes sense to implement the “next steps” module last, although it can be used in brief ways at the end of each meeting if you are doing multiple sessions.

The different modules are most effective if the physician champion can draw connections across them. If the surveys are completed in advance, the physician champion can use these results to help select the type of sample case to discuss and the type of community-based organization representative to invite. In this way, the discussion of survey results provides a good lead-in for later presentations.

Physician champions are strongly encouraged to end the meeting, or each meeting if you are doing multiple sessions, with “action steps.” Motivate the physicians and clinic staff to think about what they will do with what they have learned. Some examples of possible action steps are:

- Test out the referral form with patients that come in tomorrow.
- Follow-up with a CBO representative about a specific patient.
- Review some patient records to see how community services might be helpful.
- Bring together clinic staff and community service representatives and see what their ideas are for improving referrals.

## **Suggestions for Leading a Discussion with Physicians about Community-Based Organizations**

### **1. Suggestions about Meeting Process**

- A. Set Expectations for the Session
  - (1) Welcome participants to the session and briefly state your expectations as the physician champion. These expectations might include:
    - (a) Interactive session with participation of all
    - (b) Open discussion that encourages voicing different points of view
    - (c) Session designed for shared learning; the facilitator is not the authority
    - (d) Participants will be encouraged to develop “next steps”
- B. Introductions
  - (1) Example: Ask participants... “State your name, location and how many older adults you care for.”
- C. Rationale - Give some background information and explain the importance and benefits of connecting practicing physicians with community-based organizations. Provide an example of how partnering with a CBO has benefited your practice and patients. Convey your enthusiasm for the topic and today’s discussion.
- D. Review Agenda - Provide participants with written meeting agenda.
- E. Present one or more of the modules listed below.
- F. Summarize the discussion and respond as appropriate to questions and comments.
- G. Evaluation of Session
  - (1) Ask participants to complete a post-survey, such as the one included in this toolkit under *Tools for Gathering Information*.

### **2. Modules (All of these modules can be delivered during one meeting, or across several different meetings.)**

- A. Complete *Baseline Survey of Physicians*
  - (1) The *Baseline Survey of Physicians Regarding Care of Older Adults and Use of Community Resources* is included in this toolkit. This survey may be completed by participants and reviewed by the physician champion prior to the first meeting. If this is not possible, participants may complete the survey at the beginning of the session and results can be reviewed quickly at the time or after the session for discussion at a future session.

B. Presentation of Sample Cases and Discussion

- (1) Present sample case and associated questions to participants. It may be helpful to select and distribute sample cases prior to the meeting. Share one or more cases with meeting participants, as well as the CBO representative who will be attending.
  - (a) Included in this toolkit is the *Sample Cases* section (Section V), which includes some cases and questions, as well as tips for developing and soliciting sample cases from participants.
  - (b) You are also encouraged to use a sample case from your own practice that illustrates the benefits to you and your patients of partnering with CBOs.
  - (c) Encourage open discussion and solicit input from CBO representative.
  - (d) You may want to solicit sample cases from participants prior to the meeting for use here.

C. Presentation from Community-Based Organization Representative

Introduce representative from CBO. Encourage questions and discussion, while still keeping discussion “on track.” CBO representative should provide his/her contact information to physicians in case they have questions later.

- (1) Included in this toolkit is a section on *Engaging a Community-Based Organization Representative* for additional tips.
- (2) Also included in this toolkit is a sample *Physician to CBO Referral Form* that can be used as is, or modified to help physicians make referrals to CBOs.

D. Next Steps

(Consider doing an abbreviated version of this module at the end of each session if you are conducting multiple sessions.) The purpose of this activity is to get the physicians thinking about what changes they can make in their own practices to help integrate what they have learned during the meeting and address some of the issues raised.

- (1) Ask each participant to discuss one change he/she could make within his/her practice.
- (2) The *Worksheet of Sample Action Steps* in the *Tools for Gathering Information* section of this toolkit offers examples of actions that can get a discussion going.
- (3) The *Post Survey*, also in the *Tools for Gathering Information* section, asks a question about follow-up steps so that the meeting participants can write down what actions they are considering.
- (4) Ask each participant to identify an expected benefit to their practices and/or patients.
- (5) Follow-up at later sessions; discuss barriers to proposed changes as well as any successes.

## SECTION IV: TOOLS FOR GATHERING INFORMATION

### List of Tools

- Baseline Survey of Physicians Regarding Care of Older Adults and Use of Community Resources
- Post Survey of Physicians on Satisfaction and Action Steps
- Worksheet of Action Steps

### **What is the purpose of these tools? What problems or issues are they designed to address?**

Each of these tools is designed to provide helpful information to the physician champions, their healthcare and CBO partners, and their physician colleagues.

The *Baseline Survey* is designed to address two issues:

1. To provide the physician champions with a clearer understanding of the participating physicians' patients and experiences with community services that serve older adults. This should help him/her tailor the educational program to the specific physician participants.
2. To raise awareness among the physicians by asking them to reflect on their current patients and referral practices. By completing the survey, the physicians will recall past experiences and be able to bring those experiences to a group or one-on-one discussion.

The *Post Survey* gives the physician champion some feedback on the satisfaction of the physicians with the educational program and their plans, if any, for incorporating what they learned into practice.

The *Worksheet of Action Steps* offers suggestions that physicians can consider for incorporating what they learned into their practices. The *Worksheet* can be copied and shared with nurses and other office staff to help compile data on the needs of current patients. These needs may be directly communicated by the patients or caregivers, or simply observed by physicians, nurses, and office staff. The results may help physicians to determine which community-based organizations might be most helpful to their patients.

After reviewing the results from the *Worksheet*, review a local guide to community services (often available from the Area Agency on Aging in your community, or the United Way) to see which ones offer the services your patients need. Invite a representative from the organization to a brief meeting at the clinic to learn more about the services and to develop an effective referral and feedback process.

### **When and how should the *Tools for Gathering Information* be used?**

The *Baseline Survey* might be most helpful if it can be completed by participating physicians and reviewed by the physician champion prior to the first meeting. However, this might not be possible, so the survey can also be completed at the start of the first meeting. The physician champion can review the results quickly right at that time or can review them after the session and incorporate the results in future sessions or during one-on-one meetings. See Section III: *Effective Group Discussions with Physicians* for more ideas on using this tool.

The *Post Survey* can be used at the end of the educational program. This tool will help you determine where progress was made, and what areas might need more emphasis the next time the toolkit is implemented.

The *Worksheet* can be used in discussions at group meetings, or can be distributed to the physicians at the end of the program for them to take back and discuss with clinic staff.

**Baseline Survey of Physicians Regarding Care  
of Older Adults and Use of Community Resources**

- 1. Approximately what percentage of your clinical time is with patients age 65 or older?**
  - ?  $\leq 20\%$
  - ? 21 – 40%
  - ? 41 – 60%
  - ? 61 – 80%
  - ?  $>80\%$
  
- 2. What are the top five most difficult issues you encounter with your older patients?**
  
  
  
  
  
  
  
  
  
  
- 3. What community-based organizations have helped you care for your patients? (e.g., Meals on Wheels, Senior Centers, Alzheimer's Association, American Diabetes Association)**
  
  
  
  
  
  
  
  
  
  
- 4. How did you learn about them?**
  - a) What worked well? \_\_\_\_\_
  - b) What didn't work? \_\_\_\_\_
  
  
  
  
  
  
  
  
  
  
- 5. Do you usually receive follow up after the referral?**
  - ? Yes
  - ? No

- 6. Do you usually know if your patients actually receive the service?**
- ? Yes
  - ? No
- 7. What do most of your patients think about working with community-based organizations?**
- ? Very helpful
  - ? Somewhat helpful
  - ? Not helpful
  - ? Don't know
  - ? Other \_\_\_\_\_
- 8. How often does your office staff (as opposed to yourself) make the referrals?**
- ? Always
  - ? Occasionally
  - ? Rarely
  - ? Never
  - ? Other \_\_\_\_\_
- 9. How do you and/or your staff usually communicate with community-based organizations?**
- ? Telephone
  - ? Fax
  - ? Email
  - ? Other \_\_\_\_\_
- 10. What are some barriers you've experienced when referring patients to community-based organizations?**
- 11. What would be the best method to educate physicians about community-based organizations?**

## Post Survey of Physicians on Satisfaction and Action Steps

1. **Your level of understanding about the programs and services in community-based organizations before this discussion.**
  - ? High
  - ? Medium
  - ? Low
2. **Extent to which this discussion improved your understanding about the programs and services in community-based organizations.**
  - ? A lot
  - ? Some
  - ? Not at all
3. **Your level of interest in linking your patients to community-based organizations before this discussion.**
  - ? High
  - ? Medium
  - ? Low
4. **Extent to which this discussion increased your level of interest in linking your patients to community-based organizations.**
  - ? A lot
  - ? Some
  - ? Not at all
5. **Your confidence about offering advice to patients on community resources prior to this discussion.**
  - ? High
  - ? Medium
  - ? Low
6. **Extent to which this discussion improved your confidence about offering advice to patients on community resources.**
  - ? A lot
  - ? Some
  - ? Not at all
7. **Do you expect to follow-up on this discussion in your practice setting?**
  - ? Yes     In what way? \_\_\_\_\_
  - ? No



## **Worksheet of Sample Action Steps**

### **Learning About Your Patients**

1. Have any of your patients mentioned having a problem with transportation to and from physician's appointments? Has this been a factor when the patient is scheduling follow-up appointments with office staff?
2. How many of your patients seem to be inactive and could benefit from help to become more active?
3. Are patients having problems managing their medications: taking them appropriately; understanding associated risks; getting them paid for? If so, approximately how many?
4. How many of your patients have fallen or are likely at risk of falling due to physical inactivity, poor balance, medications, hazards at home or other reasons?
5. Have any of your patients been diagnosed with Alzheimer's Disease or other dementias? If so, how many? Could they benefit from adult day care or could their caregivers benefit from respite services or support groups?
6. Do any of your patients remark about being lonely and/or isolated; not having family members nearby; many friends have passed away?
7. Do any of your patients appear to need help with meals: getting groceries, preparing meals appropriately for their dietary needs, getting meals delivered, etc.
8. These are just examples. Pick any topic that seems to be relevant to your patients and important to you and the clinic staff.

### **Integrating CBO Referrals into Practice**

1. Talk to clinic staff about what they know about community organizations and their value to patients.
2. Find out if staff members have ideas about what your patients might need. Do they want to do some data gathering – as described above?
3. Discuss with your staff what benefits, if any, might accrue to your practice by strengthening relationships with community organizations.

4. Review the sample referral form with staff. Do they have suggestions for modifying it?
5. Discuss ways to incorporate the referral process into practice so that it is not cumbersome and time consuming. Note that if the patient will sign the referral so your office can fax it to the community organization, it is much more likely that the patient will actually get linked to a service. Suggesting to patients that they call a local organization is not as effective as making the referral directly.
6. Become familiar with some of the evidence about the positive impact of health promotion and chronic disease self-management programs, and community-based services.
7. Decide how you will know if making referrals to CBOs is helping your patients and your practice. What will you want to know?

## **SECTION V: SELECTING SAMPLE CASES TO STIMULATE DISCUSSION**

### **Why use cases?**

Case-based learning has been shown to be one of the most effective means for educating health care professionals. The use of cases, whether actual or illustrative, can serve to stimulate a more “ground-level” discussion of how primary care practices can successfully partner with community-based organizations to meet the challenging and complex needs of their older patients.

### **When to use cases?**

Clinical cases should be used in the meeting that acquaints physicians with the value of CBOs. By stimulating discussion at a more concrete level, they can help physicians understand the role community services can play in helping them improve the management of their older patients’ medical conditions, particularly for some of their more complicated (and frustrating) patients.

### **How should cases be selected?**

There is no single best approach to selecting cases for discussion. Any of the following approaches might accomplish the intended objective:

- The physician champion could share cases that s/he has struggled with recently.
- Physicians participating in the meeting could be asked to present cases of their own.
- Cases/examples may have been provided in the pre-meeting clinic survey.
- The illustrative cases included as samples in this section could be used or modified.
- Any of the four approaches above could be distributed to participating physicians prior to the meeting, as suggested templates, with a request to bring a similar case from their practice to the meeting.

In order to keep the discussion with the community agencies relevant and also to demonstrate the value of the services they provide, a few additional suggestions regarding cases are in order.

- When actual cases are selected, they will be more effective if they are ones that physicians are actively involved with, rather than cases that are more remote.
- Ideally, selected cases should provide the opportunity for more generalized learning. Thus, cases that are atypical or that reflect situations that are unlikely to be replicated may have less value to the group (i.e., try to pick a horse rather than a zebra).

- Try to present the case in such a way that minimizes the intricacies of the medical evaluation and maximizes the challenges of chronic illness management. For example, it might be best to simply state up front that the bulk of the medical evaluation has been adequately completed to allow the physician and care team (including the team nurse, medical assistant, and office staff) to focus on how best to develop or refine the care plan.

## Three Sample Cases with Discussion Questions

### Case 1

Mrs. SP is a 77-year old woman, a retired elementary schoolteacher. She lives with her daughter, son-in-law, and their two dogs. She has hypertension, osteopenia, and osteoarthritis of the knees and presents to your clinic with a chief complaint of multiple falls. Your evaluation does not reveal any evidence to suggest a cardiovascular, cerebrovascular, or vestibular etiology for her falls. Similarly, a comprehensive medication review does not identify any medications known to increase risk for falls and the patient does not drink alcohol. Her physical exam, including postural blood pressure readings, is normal with the exception of mild quadriceps weakness and a gait exam that can be characterized as cautious but with no specific neurologic deficits. Both you and Mrs. SP are concerned over the possibility of future falls and fracture. You offer to prescribe a cane but Mrs. SP declines. You prescribe a home exercise program with a pedometer but then you learn that she is very anxious about doing this on her own. You then consider a community-based, supervised physical activity program.

- Question 1. Are you familiar with the evidence that group physical activity improves function and reduces risk of injurious falls?
- Question 2. Are group physical activity programs available in your community? If so, where?
- Question 3. How would you encourage the patient and/or caregiver in agreeing to the referral?
- Question 4. What are some of the barriers that might be anticipated?
- Question 5. What is required of your office staff to make the referral? Who on your team could make this referral?
- Question 6. Are there any parameters you would like the group instructor to monitor and if so, how often and how would you like the information conveyed back to your office?
- Question 7. How will you determine whether this intervention has been effective?

## Case 2

Mrs. YN is a 69-year old woman who lives alone in an apartment complex and has no friends or family in the area. She has diabetes, mild diabetic retinopathy, hypertension, hyperlipidemia, and obesity. Last month, her hemoglobin A1c was 12. Together you feel you have exhausted all avenues to help support her and her chronic illnesses but she has not improved and just seems overwhelmed. She calls and speaks to either your front desk staff or nursing staff at least daily, seemingly needing constant reassurance. Her family, who lives in another state, has shared with you that they think she might be depressed, in part, due to her social isolation. You realize that what Mrs. YN needs is ongoing support that addresses both her medical needs and her need for greater socialization and support for self-management.

- Question 1. Are you familiar with the evidence that chronic illness self-management groups held in the community by lay-leaders can improve self-management behaviors, improve disease outcomes, and reduce utilization?
- Question 2. Are self-management groups offered in your community? If so, where?
- Question 3. How would you encourage the patient and/or caregiver in agreeing to the referral?
- Question 4. What are some of the barriers that might be anticipated?
- Question 5. What is required of your office staff to make the referral? Who on your team could make this referral?
- Question 6. Are there any parameters you would like the group instructor to monitor and if so, how often and how would you like the information conveyed back to your office?
- Question 7. How will you determine whether this intervention has been effective?

### Case 3

Mr. CL is a 80-year old retired mechanic who lives with his wife in a mobile home park. He has been evaluated in the local emergency department five times in the past month for mild exacerbations of his congestive heart failure. You reach the conclusion that the reason for these frequent visits has more to do with his cognition than his failing heart. Your evaluation confirms moderate dementia and you also recognize that his wife, who suffers from a high burden of illness herself, is experiencing considerable caregiver strain. She wants to keep her husband at home but needs help.

- Question 1. Are you familiar with the evidence that involvement of community-based agencies to support patients with dementia and their caregivers has been shown to improve outcomes, reduce caregiver hospitalization, and reduce nursing home placement?
- Question 2. Are support programs offered in your community? If so, where?
- Question 3. How would you encourage the patient and/or caregiver in agreeing to the referral?
- Question 4. What are some of the barriers that might be anticipated?
- Question 5. What is required of your office staff to make the referral? Who on your team could make this referral?
- Question 6. Are there any parameters you would like the agency to communicate back to your office and if so, how often and how would you like the information conveyed?
- Question 7. How will you determine whether this intervention has been effective?

## SECTION VI: GLOSSARY

### Health Promotion, Self-Management

#### Physical activity

*Physical activity:* Any form of exercise or movement. Physical activity may include planned activity such as walking, running, or active sports. Physical activity may also include other daily activities such as household chores, yard work, walking the dog, etc.

*Exercise:* Physical activity that is planned or structured. Involves repetitive bodily movement done to improve or maintain one or more of the components of physical fitness—aerobic fitness, muscular strength, muscular endurance, flexibility, balance, and body composition.

#### Diet & nutrition

*Home-delivered meals:* Nutrition services to provide meals for homebound older adults, frequently called Meals on Wheels. May provide special diets.

*Congregate meals:* Noon time meal served at neighborhood community center such as a senior center, church, or synagogue.

#### Support for managing chronic conditions

*Self-management:* Includes active involvement of person with chronic condition(s) in problem definition, goal setting and planning; building self-efficacy and access to supportive resources; active and sustained follow-up with positive reinforcement.

*Support groups:* A group of people who meet regularly about common issues (e.g., illness, disability, loss) and provide emotional and physical support to one another.

#### Falls prevention

*Home safety evaluation:* Review of the client's home for minor changes that make the dwelling safer. Examples of such changes are removal of throw rugs, cords and worn carpeting, addition of smoke alarms, locks, grab bars, and handrails.

*Falls education:* Aimed at helping people become aware of and concerned about the risks of falls so as to increase their readiness to adopt one or more



strategies to reduce falls (e.g., increase lighting in the house, remove area rugs, ensure proper medications management).

*Physical mobility programs:* Interventions that help older adults to move and do physical activities safely.

### Memory concerns

*Mild to moderate memory loss:* Trouble learning new material or requiring longer time to recall learned material; forgetfulness.

*Alzheimer's Association:* For persons with Alzheimer's Disease, local chapters provide face-to-face counsel and support, accurate information and professional education.

Medications management: Screening and education to prevent incorrect use of medication and adverse reactions.

### Social connections

*Senior center:* A place where older adults come together for services and activities (including physical activity and other health programs) that respond to their diverse needs and interests, support their independence, and encourage their involvement in the center and the community.

Mood concerns: Often associated with depression or anxiety.

*Outpatient mental health services:* Formal specialty services for the prevention, diagnosis, or treatment of emotional and mental health problems.

Civic engagement: A conscious connection to one's community evidenced in an individual's knowledge about problems facing their community and participation in community-based activities.

## **Services**

Care management: The process of planning, organizing, coordinating, and monitoring the services and resources necessary to respond to an individual's (health) care needs.

Information and referral/assistance: Trained staff members provide guidance and referrals to local agencies with programs and services for older adults and their caregivers.

### In-home help & housing

*Home care/Companion services:* Assistance with light housekeeping, shopping, cooking, some personal care needs, and companionship.

*Home repair services:* Minor home repairs provided by qualified individuals.

*Telephone reassurance/Friendly visitor:* For socially isolated elders to monitor their well being.

*Personal emergency response systems:* An electronic device that enables the user to contact help in case of a fall or other medical emergency.

### Personal care

*Home health care:* Time limited skilled nursing care with potential for improvement, a focus on rehabilitation provided by multiple disciplines.

*Hospice care:* Interdisciplinary services and palliative care to the terminally ill.

### Adult day care

*Adult day care (social model):* Day program designed for persons with cognitive impairment.

*Adult day health care:* Socialization and rehabilitation program provided by health professionals for functionally impaired elderly.

### Legal services

*Personal legal services:* Assistance with wills and other legal documents, as well as legal advocacy.

*Protective services:* A public program that advocates appropriate care for elderly and dependent individuals living at home. Ombudsman services exist to preserve the rights of persons living in institutional settings.

*Public guardian:* Provides guardianship services.

### Support/education for caregivers

*Respite care:* Services to provide relief for primary caregivers of persons with serious physical or mental impairment who are still living at home.

## **SECTION VII: CONTACT INFORMATION FOR NATIONAL AGING AND HEALTH ORGANIZATIONS**

### **Senior Centers and Aging Network Services**

- The National Council on the Aging  
(202) 479-1200  
[www.ncoa.org](http://www.ncoa.org)
- Administration on Aging  
(202) 619-7501  
[www.aoa.gov](http://www.aoa.gov)
- American Geriatrics Society  
(212) 308-1414  
[www.americangeriatrics.org](http://www.americangeriatrics.org)
- American Society on Aging  
(800) 537-9728  
[www.asaging.org](http://www.asaging.org)
- National Association of Area Agencies on Aging  
(202) 872-0888  
[www.n4a.org](http://www.n4a.org)
- National Association for Hispanic Elderly (Asociacion Nacional pro Personas Mayores)  
(626) 564-1988  
[www.anppm.org](http://www.anppm.org)
- National Association of State Units on Aging (NASUA)  
(202) 898-2578  
[www.nasua.org](http://www.nasua.org)
- National Caucus and Center on Black Aged  
(202) 637-8400  
[www.ncba-aged.org](http://www.ncba-aged.org)
- National Hispanic Council on Aging  
(202) 429-0789  
[www.nhcoa.org](http://www.nhcoa.org)
- National Indian Council on Aging  
(505) 292-2001  
[www.nicoa.org](http://www.nicoa.org)
- National Institute on Aging  
(800) 222-2225  
[www.nia.nih.gov](http://www.nia.nih.gov)

### **Specific Senior Services**

- American Association of Homes and Services for the Aging  
(202) 783-2242  
[www.aahsa.org](http://www.aahsa.org)

- ABA Commission of Legal Problems of the Elderly  
(202) 662-8690  
[www.abanet.org](http://www.abanet.org)
- American Society of Consulting Pharmacists  
(703) 739-1300  
[www.ascp.com](http://www.ascp.com)
- Assisted Living Federation of America  
(703) 691-8100  
[www.alfa.org](http://www.alfa.org)
- Eldercare Locator  
(800) 677-1116  
[www.eldercare.gov](http://www.eldercare.gov)
- Family Caregiver Alliance  
(800) 445-8106  
[www.caregiver.org](http://www.caregiver.org)
- Meals on Wheels Association of America  
(703) 548-5558  
[www.mowaa.org](http://www.mowaa.org)
- National Academy of Elder Law Attorneys  
(520) 881-4005  
[www.naela.org](http://www.naela.org)
- National Adult Day Services Administration  
(800) 558-5301  
[www.nadsa.org](http://www.nadsa.org)
- National Alliance for Caregiving  
(301) 718-8444  
[www.caregiving.org](http://www.caregiving.org)
- National Alliance for the Mentally Ill  
(800) 950-6264  
[www.nami.org](http://www.nami.org)
- National Asian Pacific Center on Aging  
(206) 624-1221  
[www.napca.org](http://www.napca.org)
- National Association for Home Care and Hospice  
(202) 547-7424  
[www.nahc.org](http://www.nahc.org)
- National Association of Nutrition and Aging Services Programs  
(202) 682-6899  
[www.nanasp.org](http://www.nanasp.org)
- National Association of Professional Geriatric Care Managers, Inc.  
(520) 881-8008  
[www.caremanager.org](http://www.caremanager.org)

- National Hospice Foundation  
(800) 658-8898  
[www.nho.org](http://www.nho.org)
- National Long Term Care Ombudsman Resource Center  
(202) 332-2275  
[www.ltombudsman.org](http://www.ltombudsman.org)
- National Mental Health Association  
(703) 684-7722  
[www.nmha.org](http://www.nmha.org)
- National Resource Center on Supportive Housing and Home Modification  
(213) 740-1364  
[www.homemods.org](http://www.homemods.org)
- National Senior Citizens Law Center  
(202) 289-6976  
[www.nslc.org](http://www.nslc.org)
- Visiting Nurse Associations of America  
[www.vnaa.org/vnaa/gen/html~home.aspx](http://www.vnaa.org/vnaa/gen/html~home.aspx)

### **Specific Diseases/Conditions**

- Alzheimer's Association  
(800) 272-3900  
[www.alz.org](http://www.alz.org)
- American Association for Geriatric Psychiatry  
(301) 654-7850  
[www.aagpgpa.org](http://www.aagpgpa.org)
- American Cancer Society  
(800) 227-2345  
[www.cancer.org](http://www.cancer.org)
- American Diabetes Association  
(800) 342-2383  
[www.diabetes.org](http://www.diabetes.org)
- American Foundation for the Blind  
(212) 502-7600  
[www.afb.org](http://www.afb.org)
- American Heart Association  
(800) 242-8721  
[www.americanheart.org](http://www.americanheart.org)
- American Parkinson Disease Association  
(800) 223-2732  
[www.apdaparkinson.org](http://www.apdaparkinson.org)
- Arthritis Foundation  
(800) 283-7800  
[www.arthritis.org](http://www.arthritis.org)

- National Family Association for the Deaf-Blind  
(800) 255-0411  
[www.nfadb.org](http://www.nfadb.org)
- National Federation of the Blind  
(212) 502-7600  
[www.nfb.org](http://www.nfb.org)
- National Institute of Deafness and Other Communication Disorders  
(301) 496-7243  
[www.nidcd.nih.gov](http://www.nidcd.nih.gov)
- National Osteoporosis Foundation  
(202) 223-2226  
[www.nof.org](http://www.nof.org)

## SECTION VIII: REFERENCES AND RESOURCES

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Stutz, D., Robinson, B.E., Barry, P.P. The Practicing Physician Education Project: A Toolkit for Dementia. *Annals of LTC* 9(2):42-52, Feb. 2001.

Wagner, EH. Chronic Disease Management: What will it Take to Improve Care for Chronic Illness? *Effective Clinical Practice* 1(1):2-4, Aug/Sept. 1998.

### Resources

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Collins, B.A., Hawks, J.W., Davis, R. From Theory to Practice: Identifying Authentic Opinion Leaders to Improve Care. *Managed Care* pp. 46-62, July 2000.

Davis, D.A., Taylor-Vaisey, A. Translating Guidelines into Practice: A Systematic Review of Theoretic Concepts, Practical Experience and Research Evidence in the Adoption of Clinical Practice Guidelines. *Canadian Medical Association Journal* 157(4):408-416, Oct. 1997.

Grimshaw, J.M. et al. Changing Physicians' Behavior: What Works and Thoughts on Getting More Things to Work. *Journal of Continuing Education in the Health Professions* 22(4):237, Dec. 2002.

Pereles, L. et al. The Use of the Opinion Leader in Continuing Medical Education. *Medical Teacher* 25(4):438-441, July 2003.

Soumerai, S.B. et al. Effect of Local Medical Opinion Leaders on Quality of Care for Acute Myocardial Infarction. *JAMA* 279(17):1358-1363, May 1998.

## **Web sites**

Center for Healthy Aging  
[www.healthyagingprograms.org](http://www.healthyagingprograms.org)

American Society on Aging  
[www.asaging.org](http://www.asaging.org)

Centers for Disease Control and Prevention, Healthy Aging for Older Adults  
[www.cdc.gov/aging/](http://www.cdc.gov/aging/)

Civic Engagement  
[www.respectability.org](http://www.respectability.org)

The Helpguide  
[www.helpguide.org/aging\\_well.htm](http://www.helpguide.org/aging_well.htm)

Home Health Medications Management - A Model of Care  
[www.homemeds.org](http://www.homemeds.org)

Merck Institute of Aging and Health  
[www.miahonline.org](http://www.miahonline.org)

Medication Management  
[www.safemedication.com](http://www.safemedication.com)

The National Blueprint (Physical Activity)  
[www.agingblueprint.org](http://www.agingblueprint.org)

National Policy and Resource Center on Nutrition and Aging  
[www.fiu.edu/%7Enutreldr/](http://www.fiu.edu/%7Enutreldr/)

Transportation Fact Sheet  
[www.aoa.gov/press/oam/May\\_2004/media/factsheets/Transportation%20FS.pdf](http://www.aoa.gov/press/oam/May_2004/media/factsheets/Transportation%20FS.pdf)



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  - Nancy Wilson  
Assistant Director, Huffington Center on Aging, Baylor College of Medicine, Houston, TX
  - Robert Schreiber, MD  
Physician-in-Chief, Hebrew SeniorLife, Roslindale, MA

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“As a practicing geriatrician and internist for over 18 years, I have found the use of community-based service providers to be invaluable in the care and management of my patients. Patients with cognitive impairment have a unique set of challenges. Service providers such as Minuteman Senior Services and local Councils on Aging have worked collaboratively with me to develop comprehensive care plans and provide direct patient care services that meet the functional and psychosocial needs of my patients and their caregivers. Others of my patients have benefited from activity programs and support groups at our local senior center. Without these providers’ expertise, caring for my elderly patients would be much more challenging and my patients would have diminished quality of life.

This toolkit will help me educate my colleagues about the benefits for my patients and my practice of working with community-based organizations.”

*Robert Schreiber, MD  
Physician-in-Chief  
Hebrew SeniorLife*

## **THE NATIONAL COUNCIL ON THE AGING**

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